the association between oral contraceptives and benign hepatic tumors, which is already well documented.[2-4] The question today is not "Do birth control pills cause liver tumors?" but, rather, "Why do liver adenomas occur only in some women?" Do most of these women have a problem demethylating mestranol to ethinyl estradiol? Could a screening method be developed? Methyltestosterone is metabolized with difficulty by the liver and produces creatinuria, as also do 17α-methylandrostenediol and 17α-methylandrostanediol while the esters of testosterone do not have this effect.

It is mentioned that oral contraceptives contain either mestranol or ethinyl estradiol as the synthetic estrogen. We do not agree that there is enough evidence to suggest mestranol and ethinyl estradiol are "equal offenders." The widely quoted study by Rooks and co-workers[5] unfortunately negated a difference between the two estrogens, and this aspect of their work needs further evaluation. Most individual case reports of hepatic adenoma catastrophes, including Fitz's case and ours, continue to involve a history of mestranol use, despite a dramatic steady decrease in the sales of mestranol-containing pills since 1964. It is of interest that no new low-dose oral contraceptive is being manufactured with mestranol.

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REFERENCES

1. Fitz JG: Oral contraceptives and benign tumors of the liver—Medical Staff Conference, University of California, San Francisco. West J Med 1984 Feb; 140:260-267
2. Edmonston HA, Henderson B, Benton B: Liver cell adenomas associated with the use of oral contraceptives. N Engl J Med 1976 Feb 26; 294:470-472
3. Klatskin G: Hepatic tumors: Possible relationship to use of oral contraceptives. Gastroenterology 1977 Aug; 73:386-394
4. Nissen ED, Kent DR, Nissen SE: Role of oral contraceptive agents in the pathogenesis of liver tumors. Am J Obstet Gynecol 1977 Jan 1; 127:61-66
5. Rooks JB, Ory HW, Ishak KG, et al: Epidemiology of hepatocellular adenoma—The role of oral contraceptive use. JAMA 1979 Aug 17; 242:644-648

Artificial Solutions to Health Care Problems

To the Editor: The editorial "Health Care and Not Enough Dollars"[1] struck a very resonant note. It is indeed unfortunate that our legislators and health care planners cannot understand the simple logic involved. The health-care-pool dollars are indeed finite. Efforts to solve the dilemma by diverting a portion of those precious dollars to advertising to create "competition" (obstensibly to decrease costs) only reduce the number of dollars available to serve patient needs. When businessmen steeped in the Madison Avenue hype and bureaucrats imbued in the concepts of forced competitiveness seek to apply those artificial solutions to health care delivery they fail miserably. The application of those mechanisms only opens the pool of health care dollars to the avarice of those entrepreneurs waiting and lobbying on the sidelines to siphon off large portions of that precious pool.

The real function of advertising is to stimulate a market. If it were not, advertising would not be used by business. It has no other commercial value. Advertising does not in any way create saving. If it did, it would serve no purpose in the commercial world.

Middlemen, those between providers and consumers of medical care, only consume another portion of that finite pool. Their ability to consume has been amply demonstrated. Organizers of many would-be HMOs have displayed their expertise at the old hat trick, causing millions of dollars of federal "start-up funds" to miraculously disappear.

Solutions to the problem of not enough health care dollars must come from the medical community, not from the business community or political arena.

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REFERENCE

1. Watts MSM: Health care and not enough dollars (Editorial). West J Med 1984 Feb; 140:274-275

Nutritional Aspects of Cross-cultural Medicine

To the Editor: Congratulations are due to you and your guest editor, Dr M. Margaret Clark, for the splendid special issue (December 1983) on cross-cultural medicine. You perhaps realize it could serve as a teaching publication on medical anthropology for students in the health professions and in anthropology alike. I have already commended it to a number of students in both disciplines. The choice of topics and ethnic groups considered is broad enough to be useful to professionals throughout North America and beyond. The impact and excitement of the articles and the feeling of immediacy they impart to the reader are due of course to the authors' own experiences with the patients they are describing and the insights they have thus learned. Nothing could be a better teaching tool.

As a human nutritionist and medical anthropologist specializing in nutritional anthropology I was disappointed, therefore, that discussion of the cultural and behavioral problems arising from differences in diets and food choices of minority groups from those of attending health professionals was not presented with the same sense of personal contact and awareness. Meanings of food to people must be considered in dealing with any health problems in which diet and nutritional status are concerns. Recognizing that these meanings exist and should be worked around in ways similar to treatment of those cultural differences described by the authors in the December issue is essential to mutual respect and understanding, as well as to improvement in diet and health.

There is by now a fairly large body of literature that clearly presents problems of diet change among immi-

grant and other minority groups. These have been written by nutritionists and physicians as well as social scientists, but few of the more pertinent ones are cited in the December article by Freimer and co-workers[1] on nutritional and clinical implications of cultural variation. A few examples may be cited: the work of Casey and Harrill,[2] nutritionists studying food choices of Vietnamese immigrant women in Colorado; the research of Grivetti and Paquette[3] on food choices of first-generation Chinese in California that elicited reasons for preferences for nontraditional foods, and the studies of Bindon[4] on the manner in which Samoan diets have changed with migration from rural to more urban areas of that country and subsequent moves to a western culture (Hawaii). The nutritionist Brewer[5] published a number of reports through the Los Angeles County Health Department of meal patterns and food customs and beliefs of several minority groups in that county, including blacks and Mexican-Americans as well as Samoans.

Some of the references in the paper by Freimer and associates are no longer totally accepted by others (namely, Neel's "thrifty genotype" hypothesis[1(p931)]). The present paper, unfortunately for the person interested in nutritional anthropology, is a superficial and vague treatment of the topic, lacks immediacy (the authors appear to have had little insightful experience of their own with persons of other ethnicities), contains a number of outdated references and is in places incorrect. (There are few cultures, for example, that have not already had some of their own simple carbohydrates[1(p929)].) Even the nutritional explanations offered for phenomena are not clear and concise. I would hope that at a future date some of these deficiencies might be corrected by a report or reports from nutritionists and anthropologists more familiar with this important field and its literature, and with cogent experiences to share with the journal's readers.

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REFERENCES

1. Freimer N, Echenberg D, Kretchmer N: Cultural variation—Nutritional and clinical implications, *In* Cross-cultural medicine. West J Med 1983 Dec; 139:928-933

2. Casey P, Harrill I: Nutrient intake of women relocated in Colorado. Nutr Rep Int 1977; 16:687-693

3. Grivetti LE, Paquette MB: Nontraditional ethnic food choices among first generation Chinese in California. J Nutr Educ 1978; 10: 109-112

4. Bindon JR: Breadfruit, banana, beef, and beer: Modernization of the Samoan diet. Ecol Food Nutr 1982; 12:49-60

5. Brewer TJ: Food practices of some Samoans in Los Angeles County. Los Angeles, County of Los Angeles Dept of Health Services, 1973

Passive Smoking—Corrections in Tables of April Article

TO THE EDITOR: Several typographical errors occurred in Tables 2, 3 and 4 of my recent article on passive smoking.[1] The errors are in the column headed "Deaths Due to Cancer, Percent" in each table.

Table 2 is shown here as it should have appeared. In Table 3, the "Deaths Due to Cancer" percentage for 60 to 69—Smoker should have read 59.3 and for Nonsmoker, 42.9. For 59 and younger—Nonsmoker, it should have read 42.9. In Table 4, the "Deaths Due to Cancer" percentage for 70 to 79—Smoker should have read 25.0 and for Total Group—Smoker 41.8.

Thank you for making these errors known to your readers so that they can make the corrections.

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REFERENCE

1. Miller GH: Cancer, passive smoking and nonemployed and employed wives. West J Med 1984 Apr; 140:632-635

TABLE 2.—*Causes of Death in All Women in Relation to Husbands' Smoking History*

Age Group Years	*Husbands' Smoking Group*	*Deaths Due to Cancer Number*	*Deaths From Other Causes Number*	*Deaths Due to Cancer Percent*	*Odds Ratio*	χ^2
80 and older	Smoker	14	150	8.5	1.28	0.27
	Nonsmoker	8	110	6.8		
70 to 79	Smoker	27	87	23.7	0.62	1.24
	Nonsmoker	11	22	33.3		
60 to 69	Smoker	22	20	52.4	0.40	1.99
	Nonsmoker	11	4	73.3		
59 and younger	Smoker	26	13	66.7	4.00	4.21*
	Nonsmoker	4	8	33.3		
TOTAL GROUP ..	Smoker	89	270	24.8	1.40	2.18
	Nonsmoker	34	144	19.1		
MEDIAN AGE ...	Smoker	68.0	81.0			
	Nonsmoker	71.8	83.4			

*This value is significant at the .05 level of significance.

Second table from Miller article as it should have appeared.